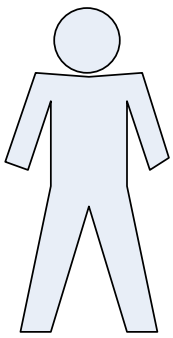
ARIZONA
MEDICAID EHR INCENTIVE PROGRAM

Reference Guide for Eligible Professionals



EP

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Subject to CMS Approval

REVISION HISTORY

Version Number	Date	Reviewer	Comments
1.0	04.07.2011	EHR Workgroup	Proposed Draft *(subject to CMS Approval)*

EHR Incentive Program

Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA or Recovery Act) provides for reimbursement incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) including critical access hospitals (CAH) participating in Medicare and Medicaid programs as they demonstrate adoption, implementation, upgrade or meaningful use of certified electronic health record (EHR) technology.

To facilitate the vision of transforming our nation's health care system to improve quality, safety and efficiency of care to EHR technology, the Health Information Technology for Economic and Clinical Health (HITECH) Act established programs under Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) have released final rules to guide and implement the provisions of the Recovery Act.

The Arizona Health Care Cost Containment System Administration (AHCCCS) is responsible for the implementation of Arizona's Medicaid EHR Incentive Program. Over the next 10 years, AHCCCS will disburse payments to providers who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation in the program and successfully demonstrate meaningful use in subsequent years.

These incentive programs are designed to support providers in this period of Health Information Technology (HIT) transition, accelerate the adoption of HIT and instill the use of qualified EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

Arizona's EHR Incentive Program

Two key components of the EHR Incentive Program are registration and attestation.

AHCCCS' Division of Health Care Management (DHCM) has fiduciary responsibility to ensure that Medicaid supplemental funds are disbursed accurately in compliance with federal and state regulations.

AHCCCS' EHR Electronic Provider Incentive Payment System (ePIP) facilitates the processing of provider incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Registration

The registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a Federal and State level registration process.

Attestation

The attestation process allows the providers to attest to the EHR Incentive Program's eligibility criteria as they demonstrate adoption, implementation, upgrade or meaningful use of EHR technology.

Provider Outreach & Recruitment

The Arizona Regional Extension Center (REC) is one of 62 RECs nationwide designated to serve Arizona as an unbiased, trusted resource with national perspective and local expertise to assist healthcare providers with electronic health record (EHR) adoption, optimization and achievement of Meaningful Use. The program is a led by Arizona Health-e Connection (AzHeC) in collaboration with Arizona State University's Department of Biomedical Informatics (ASU-BMI) and Health Services Advisory Group (HSAG).

The REC serves as a neutral source for credible EHR and HIT information—something much needed as healthcare providers seek to navigate EHR options and select vendors who meet new federal Meaningful Use requirements.

The REC strives to fully identify and provide solutions to the challenges Arizona healthcare providers face in adopting EHR systems. Finally, and most important, the program provides critical, "hands-on" services for EHR adoption as outlined below.

Regional Extension Center Services	
General Assistance	Technical Assistance
▪ Outreach and education ▪ Workforce support ▪ Tools and resources in all aspects of electronic health record (EHR) and health information technology (HIT)	▪ Vendor selection and preferred pricing ▪ Project management ▪ Practice and workflow redesign ▪ System implementation ▪ Interoperability and health information exchange (HIE) ▪ Privacy and security

The REC has a unique national perspective and local expertise and is committed to building connection and collaboration among the state's healthcare community, ensuring that the individuals and organizations are connected to the right people, tools and resources to optimize success of EHRs and achievement of Meaningful Use of EHRs.

To take advantage of the REC services, please contact them directly at:

Arizona Regional Extension Center
3877 N. 7th Street, Suite 130
Phoenix, AZ 85014
602.688.7200
www.azhec.org

EHR Incentive Program
Federal Pre-Registration

Getting Ready for Federal Registration

Providers opting to receive EHR incentive payments must first register with the CMS Registration & Attestation System. Before registering, you must have the proper enrollment records in the appropriate systems. Let's look at these pre-registration activities that will prepare you for registration!

Completing the Federal Pre-Registration is recommended before completing the Federal Registration.

Begin Here First!		
Pre-Registration Checklist	In order to register on the CMS Registration & Attestation System, you will need the following:	
	EHR IP	Eligible Professionals must select either Medicare EHR Incentive Program or Medicaid EHR Incentive Program
	I&A	CMS Identity & Access Management User ID & Password
	NPI	National Provider Identifier (NPI) *(if reassigning incentive payment, must also have Payee NPI)*
	NPPES	National Plan & Provider Enumeration System (NPPES) User ID & Password
	PECOS	Provider Enrollment Chain and Ownership System Enrollment Record *(All EHs, All Medicare EPs)*
	STATE	Medicaid EHR State *(You Decide if you will participate in the Medicaid EHR Incentive Program)*
	TIN	Tax Identification Number *(if reassigning incentive payment, must also have Payee TIN)*

Tell Me More!	
NPI	The National Provider Identifier (NPI) is a *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. When covered health care providers, health plans, and health care clearinghouses submit claims/encounter data, they will use the NPI in the administrative and financial transactions adopted under HIPAA. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have an active National Provider Identifier. If you do not have an NPI, navigate to the CMS National Plan and Provider Enumeration System website to apply. https://nppes.cms.hhs.gov/NPPES/Welcome.do
NPPES	The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a National Plan & Provider Enumeration System (NPPES) web user account. If you do not have a NPPES, navigate to National Plan and Provider Enumeration System to apply. https://nppes.cms.hhs.gov/NPPES/Welcome.do
PECOS	The Provider Enrollment, Chain and Ownership System (PECOS) is the national repository of enrolled Medicare Fee For Service Providers and Suppliers. To participate in the EHR Incentive Program, All Eligible Hospitals and All Medicare Eligible Professionals must have an enrollment record in PECOS. *Eligible Professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS.* If you do not have a PECOS enrollment record, navigate to the CMS PECOS website to apply. http://www.cms.gov/EHRIncentivePrograms/Downloads/Medicare_EP_PECOS_Notification_61110.pdf
I&A	The CMS Identify & Access Management (I&A) assigns NPPES & PECOS User IDs and passwords. If you are an EP and do not have a NPPES or PECOS or an EH without a PECOS, navigate to the I&A website to apply. https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do

EHR Incentive Program
CMS Registration & Attestation Systems
Federal Portal

Summary

The CMS Registration and Attestation System web portal is used for the facilitation of the Medicare and Medicaid EHR Incentive Programs.

To participate in the EHR Incentive Program, providers must first complete a Federal level registration process.

Completing the Federal Registration is a prerequisite for completing the State Registration.

CMS Registration & Attestation System	
CMS Registration	**Federal Registration** https://ehrincentives.cms.gov Providers must register with the CMS Registration & Attestation System to commence the EHR incentive payment process. If seeking the Medicaid incentive payment, providers must complete the state level registration at the state's web portal.
	Successful Registrations Completed Federal Registrations are assigned a CMS Registration ID. You will need this to access the State Registration. Providers opting to receive Medicaid incentive payments from Arizona after successfully completing Federal Registration will be required to register with AHCCCS' Electronic Provider Incentive Payment (ePIP) website. After 24-48 hours, providers may initiate the state registration process. EPs may only switch once over the duration of the entire EHR Incentive Program but this must occur before 2015.

EHR Incentive Program
State Pre-Registration

Getting Ready for State Registration

Providers opting to receive Medicaid incentive payments from Arizona must register with AHCCCS' EHR Electronic Provider Incentive Payment (ePIP) System. Before registering, you must have the proper identification numbers. Let's look at these pre-registration activities that will prepare you for registration!

Completing the State Pre-Registration is recommended before completing the State Registration.

Begin Here First!		
Pre-Registration Checklist	In order to register on the EHR Electronic Provider Incentive Payment System, you will need the following:	
	AHCCCS Provider ID	assigned by AHCCCS to an accepted provider for participating in the AHCCCS Program
	EHR Certification Number	assigned by ONC-Authorized Testing & Certification Board after an EHR system has been successfully certified
	CMS Registration ID	assigned by CMS Registration & Attestation System after completing the Federal Registration
	NPI	National Provider Identifier (NPI) *(if reassigning incentive payment, must also have Payee NPI)*
	TIN	Tax Identification Number *(if reassigning incentive payment, must also have Payee TIN)*

Tell Me More!	
EHR CERTIFICATION NUMBER	The EHR Certification Number is assigned by Office of National Coordinator -Authorized Testing & Certification Board (ONC-ATCB) after an EHR system has been successfully certified. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a CMS Certification Number for their EHR System. If you do not have a EHR Certification Number, navigate to the Office of National Coordinator for Health Information Technology Certified Health IT Product List website. http://onc-chpl.force.com/ehrcert
CMS REGISTRATION ID	The CMS Registration ID is assigned by the CMS Registration & Attestation System after successfully completing the Federal Registration. You need this number in order to register at the state level. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a CMS Registration ID. If you do not have a CMS Registration ID, navigate to the CMS Registration & Attestation System website. https://ehrincentives.cms.gov/hitech/login.action
NPI	The National Provider Identifier (NPI) is a *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. When covered health care providers, health plans, and health care clearinghouses submit claims/encounter data, they will use the NPI in the administrative and financial transactions adopted under HIPAA. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have an active National Provider Identifier. If you do not have an NPI, navigate to the CMS National Plan and Provider Enumeration System website to apply. https://nppes.cms.hhs.gov/NPPES/Welcome.do

Medicaid EHR Incentive Program
EHR Electronic Provider Incentive Payment System (ePIP)
State Portal

Summary

Arizona's EHR Electronic Provider Incentive Payment System (ePIP) web portal is used for the facilitation of the Medicaid EHR Incentive Program.

To participate in the Medicaid EHR Incentive Program, providers must complete a State level registration process after successfully completing the Federal level registration process.

Completing the State Registration is a prerequisite for completing the State Attestation.

EHR Electronic Provider Incentive Payment System (ePIP)	
Step 1 Register	Providers must register with the EHR Electronic Provider Incentive Payment System to initiate the Medicaid EHR Incentive Program.
Step 2 Attest	Providers must meet specific attestation requirements to qualify for the Medicaid EHR Incentive Program.
Step 3 Status	Providers may sign on to the ePIP System at any time to get information about their attestation and payment status. Once the provider completes the registration process, the ePIP System starts to report the account status.

ePIP
Provider Registration
Eligible Professionals
Step 1

Summary

Providers must register with the EHR Electronic Provider Incentive Payment System to initiate the Medicaid EHR Incentive Program.

Completing the State Registration is a prerequisite for completing the State Attestation.

ePIP State Level Registration	
Register	**State Registration** https://www.azepip.gov **Available July 2011** Use this Tab to perform the following functions: o Register in the Medicaid EHR Incentive Program o Terminate participation in the Medicaid EHR Incentive Program In order to complete registration, you must complete the following registration actions: ☑ User Agreement ☑ User Identification ☑ User Validation ☑ User Web Account
Begin Here First!	
Items From State Pre-Registration Checklist	In order to register on the EHR Electronic Provider Incentive Payment System, you will need the following: ☑ AHCCCS Provider ID ☑ EHR Certification Number ☑ CMS Registration ID ☑ NPI *(if reassigning incentive payment, must also have Payee NPI)* ☑ TIN *(if reassigning incentive payment, must also have Payee TIN)*
Actions	
User Agreement	Eligible Providers are AHCCCS Providers who agree to create an ePIP web account in order to participate in the Medicaid EHR Incentive Program. In addition, such providers and if applicable their payment designee (payee) must agree to have an electronic funds transfer record with AHCCCS in order to receive payments.
User Identification	Eligible Providers are required to provide identifying security data to gain access to the system. *(i.e. NPI, TIN, CMS Registration ID & AHCCCS Provider ID)*
User Validation	☑ Validate Pre-filled data feed from CMS Registration & Attestation System *(i.e. NPI, TIN, AHCCCS Provider ID, EHR Certification Number, Email, Name, Business Address, Business Phone, Participation Year, Business Classification and Provider Specialty)* *If pre-filled data is incorrect, exit ePIP and navigate to the CMS Registration & Attestation Systems to perform corrective action.*
	☑ Select Payee TIN Type — Select one: ☐ SSN Payee TIN Type indicates the Provider receives the payment ☐ EIN Payee TIN Type indicates the Entity receives the payment
User Web Account	☑ ePIP Login & Password — ☑ System assigns ePIP User ID *(same as AHCCCS Provider ID)* ☑ Provider confirms email address ☑ Provider creates ePIP User Password

ePIP
State Level Attestation
Eligible Professionals
Step 2

Summary

Providers must meet specific attestation requirements to qualify for the Medicaid EHR Incentive Program.

To participate in the Medicaid EHR Incentive Program, providers must complete a State level attestation process after successfully completing the State level registration process.

Annual re-attestation is required for each incentive payment.

Completing the State Attestation is a prerequisite for determining the incentive payment.

ePIP State Level Attestation	
Attest	**State Attestation** https://www.azepip.gov **Available July 2011** Use this Tab to perform the following functions: o Attest for the Medicaid EHR Incentive Program o Modify Existing Attestation o View Attestation Summary In order to complete attestation, you must complete the following attestation actions: ☑ AIU Election Criteria ☑ Provider Type Criteria ☑ License & Sanctions Criteria ☑ Patient Volume Threshold Criteria Additional Requirements are needed for FQHC/RHC EPs & PAs, Non-Hospital Based EPs & Pediatricians
Begin Here First!	
Attestation Checklist	In order to attest on the EHR Electronic Provider Incentive Payment System, you will need the following: ☑ ePIP User ID & Password ☑ EHR Certification Number ☑ FQHC/RHC EP Practices Predominantly Reporting Period *(A 6-month period in Prior Calendar Year)* ☑ FQHC/RHC Facility Patient Encounters *(in FQHC /RHC EP Practices Predominantly Reporting Period)* ☑ FQHC/RHC PA Led Type ☑ FQHC/RHC Total Needy Individuals Patient Encounters *(Title XIX, Title XXI, Patients Paying Below Cost)* ☑ Practice Demographics *(Group Practice or Clinic's Name, Address)* ☑ Practice Patient Volume Methodology *(Group Practice or Clinic)* ☑ Practice Provider Name & AHCCCS Provider ID *(Group Practice or Clinic)* ☑ Inpatient Hospital Patient Encounters *(hospital-based)* ☑ Emergency Department Patient Encounters *(hospital-based)* ☑ Medicaid Patient Encounters (AZ and each Out-of-State) ☑ Patient Volume Reporting Period *(A Continuous 90-day Period in the Prior Calendar Year)* ☑ Provider Type ☑ Physician Type ☑ Total Patient Encounters ☑ Total Patient Encounters *(in FQHC /RHC EP Practices Predominantly Reporting Period)*

ePIP
Attest to AIU Election Criteria
Eligible Professionals
Step 2a

Summary

Eligible Providers must obtain certified EHR technology and attest to Adoption, Implementation or Upgrade of their system in order to participate in the first year of the Medicaid EHR Incentive Program.

Criteria

Completing the State Attestation is a prerequisite for determining the incentive payment.

AIU Election			
	AIU Attestation Requirement		**AIU Documentation Requirement**
Select Adoption, Implementation or Upgrade (AIU)	**A**	Adoption of an EHR system requires that a provider acquired, purchased or secured access to certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider acquired, purchased or secured access to certified EHR technology.
	I	Implementation of an EHR system requires that a provider installed or commenced utilization of certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider installed certified EHR technology or basic production reports verifying the provider commenced utilization of certified EHR technology.
	U	Upgrade of an EHR system requires that a provider upgraded from existing EHR technology to certified EHR technology or expanded the functionality of existing certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider upgraded to certified EHR technology or expanded functionality of the existing certified EHR technology.
	AIU Type:		Eligible Provider Selects one of the above AIU methods
Attestation Requirement	YES or NO	☑ Eligible Provider selects attestation method ☑ Eligible Provider provides EHR Certification Number ☑ Eligible Provider uploads proof of AIU compliance	
Exceptions	None		
Ineligible	Providers without proof of AIU are not eligible for the Medicaid EHR Incentive Program		

Definitions

Adoption, Implementation or Upgrade **(**AIU) attestation requires the provider to obtain certified EHR technology for the first year (AIU1) of participation.

Meaningful Use (MU) attestation requires the provider to provide quantitative measures to substantiate meaningful use for a contiguous reporting period of 90 days for the first Meaningful User year (MU1) and the entire year for subsequent MU years. Medicaid Meaningful Use attestations will not be available in 2011. Functionality is currently being developed for deployment in 2012.

ePIP
Attest to Provider Type Criteria
Eligible Professionals
Step 2b

Summary

Providers must meet a specific Provider Type eligibility requirement to qualify for the EHR Incentive Program.

Criteria

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria		
Select Type of Eligible Professionals (EP)	Eligible Professionals (EPs) are: o Physicians (Doctor of Medicine, Doctor of Osteopathy) o Dentists o Nurse practitioners o Certified nurse midwives o Physician Assistants (PA) practicing in a FQHC/RHC led by the PA	
Attestation Requirement	YES or NO	EP attests to meeting one of the above provider types
Exceptions	None	
Ineligible	Provider Types not listed are not eligible for the Medicaid EHR Incentive Program	

Additional Requirements

In addition to the above provider eligibility requirement, Physician Assistants (PA) in FQHC/RHC must meet the below criteria to qualify to participate in the EHR Incentive Program.

Physician Assistant (PA) Eligibility Criteria		
Select Type of PA Led	FQHC/RHC PA are eligible if they satisfy one of the following requirements: o PA is the primary provider in a clinic *(Example part-time physician and full-time PA)* o PA is a clinical or medical director at a clinical site of practice o PA is an owner of an RHC	
	PA Led Type:	Eligible Provider Selects one of the above PA Led types
Attestation Requirement	YES or NO	PA attests to meeting one of the above PA provider types
Exceptions	None	
Ineligible	PA not in FQHC/RHC are not eligible for the Medicaid EHR Incentive Program	

ePIP
Attest to License & Sanctions Criteria
Eligible Professionals
Step 2c

Summary

Eligible Providers must have the proper licenses/certifications and not have active unresolved sanctions. AHCCCS will use existing operational protocols to validate licensure and sanctions.

Criteria

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria		
License & Sanctions	Eligible Provider must be an active AHCCCS Provider and in good standing	
	License	☑ Eligible Provider has proper license/certification
	Sanctions	☑ Eligible Provider does not have current sanctions
Attestation Requirement	YES or NO	☑ Eligible Provider attests to possessing proper license/certification ☑ Eligible Provider attests to clearance of any sanctions
Exceptions	None	
Ineligible	Providers not licensed are not eligible for the Medicaid EHR Incentive Program Providers with sanctions are not eligible for the Medicaid EHR Incentive Program	

Definitions

Eligible Providers must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

Eligible Providers may be sanctioned by AHCCCS for violations of the terms of the AHCCCS Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the AHCCCS provider. Sanctions must be resolved before disbursement of the EHR incentive payment.

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d

Summary

Arizona's EHR Incentive Program has adopted CMS' Patient Encounter Methodology. Eligible Providers (excluding Children's Hospitals) are required to meet specific patient volume thresholds annually to be eligible for the EHR incentive payment. Pediatricians have a special exception in meeting the patient volume. EPs in an FQHC/RHC will be evaluated according to their "needy individuals" patient volume.

Criteria

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria				
Patient Volume	EP reports Medicaid Patient Encounters & Total Patient Encounters in Patient Volume Reporting Period			
	Physician Type			Select One: ☐ Pediatrician ☐ Non-Pediatrician
	Patient Volume Reporting Period:			A Continuous 90-day Period in the Prior Calendar Year
	A	**Numerator**	Medicaid Patient Encounters	Number of Unique Medicaid Patient Encounters in denominator
	B	**Denominator**	Total Patient Encounters	Number of All Unique Total Patient Encounters in Patient Volume Reporting Period
	Patient Volume Threshold Percentage			☑ ePIP calculates: [Numerator / Denominator] x 100
Attestation Requirement	YES or NO	EP attests to meeting the provider type patient volume threshold		
Exceptions	1. *Pediatricians have special eligibility and payment rules. 2. *EPs in a Group Practice or Clinic are permitted to use the Group Practice or Clinic's patient volume as a proxy for their own under special conditions. 3. *FQHC/RHC's Patient Encounters are Total Needy Individuals Patient Encounters. 4. Eligible Providers have the option to include out-of-state patient encounters in their eligible patient volume threshold. If electing to do so, they must report each state's Medicaid encounters separately. This will trigger an eligibility verification audit and require AHCCCS to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated. **See Additional Requirements*			
Ineligible	EPs not meeting the provider type patient volume threshold are not eligible for the Medicaid EHR Incentive Program			

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d Continue

Definitions

For purposes of calculating EP Patient Volume, Medicaid Encounters are services rendered to an individual on any one day where Medicaid paid for part or all of the service, individual's premiums, copayments and/or cost-sharing.

For purposes of calculating FQHC/RHC EP Needy Individuals Patient Volume, Needy Individuals Patient Encounters are services rendered to an individual on any one day to where Medicaid or Children's Health Insurance Program (CHIP) paid for part or all of the service, individual's premiums, co-payments, and/or cost sharing; or Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

The Patient Volume Threshold percentage is defined as the total Medicaid patient encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100.

The qualifying patient volume thresholds for Medicaid EHR Incentive Program are given in the following:

Entity	Minimum 90-day Medicaid Patient Volume Threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC – 30% needy individual patient volume threshold
Physicians	30%	
Pediatricians	30% or optional 20%	
Dentists	30%	
Certified nurse Midwives	30%	
Physician Assistants when practicing at an FQRC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	N/A
Children's hospital	N/A	N/A

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d

Additional Requirements – Non-Hospital Based

EPs cannot be hospital-based. EP's patient encounters will be evaluated to determine if rendered services in a hospital-based place of service exceeds the 90% or more threshold percentage.

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria				
Hospital Based Percentage	EP reports Hospital-Based Patient Encounters & Total Encounters in Patient Volume Reporting Period.			
	Patient Volume Reporting Period:			A Continuous 90-day Period in the Prior Calendar Year
	A	Inpatient Hospital Patient Encounters		Number of Unique Inpatient Hospital Patient Encounters in numerator
	B	Emergency Department Patient Encounters		Number of Unique Emergency Department Patient Encounters in numerator
	EP Hospital-Based Patient Encounters			☑ ePIP calculates: A + B
	D	**Numerator**	EP Hospital-Based Patient Encounters	Number of Unique Hospital-Based Patient Encounters in denominator
	E	**Denominator**	Total Patient Encounters	Number of All Unique Patient Encounters in Patient Volume Reporting Period
	EP Hospital-Based Percentage			☑ ePIP calculates: [Numerator / Denominator] * 100
Attestation Requirement	YES or NO	EP attests to meeting Non-Hospital Based criteria		
Exceptions	Not applicable to EPs practicing in FQHCs/RHCs			
Ineligible	EPs with 90% or more of their encounters in a hospital-base place of service are not eligible for the Medicaid EHR Incentive Program			

Definitions

For purposes of determining Medicaid's EHR Incentive Program eligibility, Hospital-based Eligible Professionals have 90 percent or more of their covered professional services in a hospital setting and therefore do not qualify for the Medicaid EHR Incentive Program.

A hospital setting is an inpatient hospital place of service or an emergency department place of service.

Hospital-Based Encounters are encounters received at an inpatient hospital place of service or at an emergency department place of service.

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d Continue

Additional Requirements – Pediatricians

Pediatricians have a special exception to satisfy an optional patient volume.

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria - Pediatricians				
Patient Volume	EP reports Medicaid Patient Encounters & Total Patient Encounters in Patient Volume Reporting Period			
	Physician Type			☑ Pediatrician
	Patient Volume Reporting Period:			A Continuous 90-day Period in the Prior Calendar Year
	A	**Numerator**	Medicaid Patient Encounters	Number of Unique Medicaid Patient Encounters in denominator
	B	**Denominator**	Total Patient Encounters	Number of All Unique Total Patient Encounters in Patient Volume Reporting Period
	Patient Volume Threshold Percentage			☑ ePIP calculates: [Numerator / Denominator] x 100
Attestation Requirement	YES or NO	EP attests to meeting the provider type patient volume threshold		
Exceptions	None			
Ineligible	EPs not meeting the provider type patient volume threshold are not eligible for the Medicaid EHR Incentive Program			

Definitions

For purposes of determining Medicaid's EHR Incentive Program eligibility, Pediatricians are physicians who treat and diagnose illness and injuries in children under the AHCCCS Medicaid program. As such, Pediatricians must be an AHCCCS Provider who meets the physician scope of practice rules, hold a Doctor of Medicine or Doctor of Osteopathy degree, and hold a current license and board certified in Pediatrics.

A Pediatrician Patient Volume has a special exception to satisfy either:

- a minimum 20% patient volume but receives for 2/3 of the incentive payment or
- a minimum 30% patient volume for the full incentive payment

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d Continue

Additional Requirements – Group Practices or Clinics

The Group Practice or Clinic, *referred to below as 'Practice'*, must decide if each provider will use individual patient volume or the Practice's aggregate patient volume.

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria – Group Practice				
Patient Volume	EP reports Medicaid Patient Encounters & Total Patient Encounters in Patient Volume Reporting Period			
	Practice Demographics			☑ Practice Name ☑ Practice Address
	Practice Patient Volume Methodology			Select One: ☐ Individual Patient Volume Methodology ☐ Aggregate Patient Volume Methodology
	Practice Documentation			☑ Practice Documentation *(Letterhead showing agreed upon methodology, Administrator's email, each provider's name & AHCCCS Provider ID)*
	Patient Volume Reporting Period:			A Continuous 90-day Period in the Prior Calendar Year
	A	**Numerator**	Medicaid Patient Encounters	Number of Unique Medicaid Patient Encounters in denominator
	B	**Denominator**	Total Patient Encounters	Number of All Unique Total Patient Encounters in Patient Volume Reporting Period
	C	**Patient Volume Threshold Percentage**		☑ ePIP calculates: [Numerator / Denominator] x 100
Attestation Requirement	YES or NO	☑ EP attests to meeting the provider type patient volume threshold ☑ EP attests to selected Practice Patient Volume Methodology ☑ EP uploads proof of agreed upon Practice Patient Volume Methodology		
Exceptions	None			
Ineligible	EPs not meeting the provider type patient volume threshold are not eligible for the Medicaid EHR Incentive Program EPs selecting different methodologies within the Practice are not eligible for the Medicaid EHR Incentive Program			

Definitions

If using the Aggregate Patient Volume Methodology, the entire patient data of the Group Practice or Clinic's Medicaid patient volume can be used as a proxy for all EPs in the Practice if all of the following are met:

- Group Practice or Clinic's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. if an EP only sees Medicare, commercial or self-pay patients, this is not an appropriate calculation)
- There is an auditable data source to support the Group Practice or Clinic 's patient volume determination
- All of the EPs in the Group Practice or Clinic must use the same methodology for the payment year
- Group Practice or Clinic uses the entire Group Practice or Clinic's patient volume and does not limit patient volume in any way
- If EP works both inside & outside of the Group Practice or Clinic, then the patient volume calculation includes only those encounters associated with the Group Practice or Clinic and not the EP's outside encounters.

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d Continue

Additional Requirements – FQHC/RHC

EPs in an FQHC/RHC determine their FQHC/RHC patient encounters based on needy individuals.

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria - FQHC/RHC EP Patient Encounters				
FQHC/RHC EP Needy Individuals Patient Encounter Percentage	EP reports FQHC/RHC Needy Individuals Patient Encounters & Total Patient Encounters in Patient Volume Reporting Period			
	Patient Volume Reporting Period:			A Continuous 90-day Period in the Prior Calendar Year
	FQHC/RHC Total Needy Individuals Patient Encounters			
	A	Medicaid Title XIX Patient Encounters		Number of Unique Medicaid Title XIX Patient Encounters in numerator
	B	CHIP TITLE XXI Patient Encounters		Number of Unique CHIP TITLE XXI Patient Encounters in numerator
	C	Patients Paying Below Cost Patient Encounters		Number of Unique 'Patients Paying Below Cost' Patient Encounters in numerator
	FQHC/RHC Total Needy Individuals Patient Encounters			☑ ePIP calculates: A + B + C
	FQHC/RHC Patient Volume Threshold Percentage			
	D	**Numerator**	FQHC/RHC Total Needy Individuals Patient Encounters	Number of Unique FQHC/RHC Total Needy Individuals Patient Encounters in denominator
	E	**Denominator**	Total Patient Encounters	Number of All Unique Total Patient Encounters in Patient Volume Reporting Period
	FQHC/RHC Patient Volume Threshold Percentage			☑ ePIP calculates: [Numerator / Denominator] * 100
Attestation Requirement	YES or NO	EP attests to meeting the provider type patient volume threshold		
Exceptions	*EPs in a Group Practice or Clinic are permitted to use the Group Practice or Clinic's patient volume as a proxy for their own under special conditions. **See Additional Requirements for Group Practices or Clinics*			
Ineligible	EPs not meeting the provider type patient volume threshold are not eligible for the Medicaid EHR Incentive Program			

Definitions

For purposes of calculating FQHC/RHC EP Needy Individuals Patient Volume, Needy Individuals Patient Encounters are services rendered to an individual on any one day to where Medicaid or Children's Health Insurance Program (CHIP) paid for part or all of the service, individual's premiums, co-payments, and/or cost sharing; or Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

ePIP
Attest to Patient Volume Criteria
Eligible Professionals
Step 2d Continue

Additional Requirements – FQHC/RHC Practices Predominantly

FQHC/RHC EPs must demonstrate that they practice predominantly at FQHC/RHC facilities.

Completing the State Attestation is a prerequisite for determining the incentive payment.

Provider Eligibility Criteria			
FQHC/RHC EP Practices Predominantly Percentage	EP reports FQHC/RHC Facility Patient Encounters & Total Patient Encounters in FQHC/RHC EP Practices Predominantly Reporting Period		
	FQHC/RHC EP Practices Predominantly Reporting Period:		A 6-Month Period in Prior Calendar Year
	A	FQHC/RHC Facility Patient Encounters in FQHC/RHC EP Practices Predominantly Reporting Period	Number of Unique FQHC/RHC Facility Patient Encounters in denominator
	B	Total Patient Encounters in FQHC/RHC EP Practices Predominantly Reporting Period	Number of All Unique Patient Encounters in FQHC/RHC EP Practices Predominantly Reporting Period
	FQHC/RHC EP Practices Predominantly Percentage		☑ ePIP calculates: [Numerator / Denominator] * 100
Attestation Requirement	YES or NO	EP attests to practicing more than 50% at FQHC/RHC Facilities *(practices predominantly)*	
Exceptions	None		
Ineligible	FQHC/RHC EPs not practicing more than 50% at FQHC/RHC Facilities are not eligible for the Medicaid EHR Incentive Program		

Definitions

For purposes of determining Medicaid's EHR Incentive Program eligibility, 'Practices Predominantly' is defined as an EP for whom the clinical location for over 50 percent of his/her patient encounters over a period of 6 months in the prior calendar year occur at a FQHC/RHC.

ePIP
Status
Eligible Professionals
Step 3

Summary

Providers may sign on to the ePIP System at any time to get information about their attestation and payment status. Once the provider completes the registration process, the ePIP System starts to report the account status.

Completing the State Attestation is a prerequisite for determining the status of the incentive payment.

ePIP Status

Status

State Status
https://www.azepip.gov
Available July 2011

Use this Tab to perform the following functions:
- Status of Attestation
- Status of Payment

In order to check your account status, you must complete the following action:

☑ Attestation

Begin Here First!

Checklist

In order to check the status of your EHR incentive payment, you must log into the EHR Electronic Provider Incentive Payment System. You will need the following:

☑ ePIP User ID
☑ ePIP User Password

Actions

Check Status

The following milestones will be tracked:
- Attestation
- Payments

ePIP System Status Notification Indicators	
Status Indicators	**Status Descriptions**
In Progress	Action initiated but not yet completed
On Hold	Action on hold for additional information
Completed	ACCEPTED – Action Completed
	REJECTED – Action Completed

Medicaid EHR Incentive Program
Eligible Professionals
Payment Rules

Summary

Incentive payments for the Medicaid EHR Incentive Program will be made approximately 90-days after an Eligible Provider successfully meet the program's eligibility requirements. EP payments are disbursed on a rolling calendar year basis following verification of eligibility for the payment year.

Payments

EP incentive payments are predetermined based on a scheduled of payments over six years.

Pediatricians have a special exception in meeting the patient volume which reduces their payment.
- Pediatricians with a minimum of 20% patient volume threshold receive 2/3 of the incentive payment.
- Pediatricians with a minimum of 30% patient volume threshold receive the full incentive payment.

Year	Attestation Requirement	EP Payment Amount EP with 30% PV Pediatrician 30% PV	EP Payment Amount Pediatrician 20% PV
Year 1	AIU	$21,250	$14,167
Year 2	MU	$8,500	$5,667
Year 3	MU	$8,500	$5,667
Year 4	MU	$8,500	$5,667
Year 5	MU	$8,500	$5,667
Year 6	MU	$8,500	$5,667
Total EHR Incentive Payment		**$63,750**	**$42,500**

Payment Limitations

1. EPs cannot receive more than $63,750 over a six year period.
   Pediatricians have a special exception in meeting the patient volume which reduces their payment.
   - Pediatricians with a minimum of 20% patient volume threshold cannot receive more than $42,500 over a six year period.
   - Pediatricians with a minimum of 30% patient volume threshold cannot receive more than $63,750 over a six year period.
2. EPs may not begin receiving payments any later than calendar year 2016.
3. EPs may receive payments on a non-consecutive, annual basis.
4. No payments may be made after calendar year 2021.
5. EPs must participate in one EHR Incentive Program and must select either the Medicare EHR Incentive Program or Medicaid EHR Incentive Program.
6. EPs may switch once between the Medicare EHR Incentive Program and Medicaid EHR Incentive Program but the switch must occur before 2015.
7. EPs may receive an incentive payment from only one State in a payment year.
8. EPs may elect to re-assign their incentive payment to an AHCCCS provider such as an employer, group or facility (payee).
9. EPs may only receive an incentive payment from either the Medicare EHR Incentive Program or Medicaid EHR Incentive Program.
10. EP & Payee must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.
11. There are no payment adjustments or penalties for Medicaid Eligible Providers.
12. Payments may be recouped in cases of fraud, abuse or if AHCCCS' audit determines the provider was ineligible for the EHR incentive payment.

Medicaid EHR Incentive Program
Eligible Professionals
System Access IDs

Summary

Eligible Providers will need their User IDs and passwords from various systems.

Eligible Professional Data Elements				Provider Enters	
PROVIDER	**Provider Analysis Results**	EHR Incentive Program		Select 1	Select 1 Medicaid EHR Incentive Program Medicare EHR Incentive Program
	State	Medicaid State			Enter Medicaid State if selecting Medicaid EHR Incentive Program Or None (for Not Applicable)
	Tax Identification Number	TIN	Provider		Enter Provider TIN
			Payee		Enter Payee TIN
			Type	Select 1	Select TIN Type SSN Payee TIN (Individual) EIN Payee TIN (Business)
CMS	**CMS Identity and Access Management**	I&A	User ID		Check I&A ID
			Password		Check I&A Password
	National Provider Identifier	NPI			Enter NPI
	National Plan & Provider Enumeration System	NPPES	User ID		Check NPPES ID
			Password		Check NPPES Password
	Provider Enrollment Chain & Ownership System	PECOS			Check PECOS to ensure EH or EP selecting Medicare has Active Enrollment Record
	CMS Registration & Attestation System	CMS Registration ID			Assigned from CMS Registration & Attestation System Enter in State's ePIP System
ONC	**ONC-Authorized Testing & Certification Board**	EHR Certification Number			Retrieve from ONC-ATCB website for your Certified EHR System
AHCCCS	**AHCCCS Provider Agreement**	AHCCCS Provider ID			Retrieve Your Current AHCCCS Provider ID
	Electronic Provider Incentive Payment	ePIP	User Name		Assigned from State EHR System (ePIP)
			Password		Provider Sets ePIP Password

Medicaid EHR Incentive Program
Eligible Professionals
Patient Volume Data Elements

Summary

Eligible Providers must report components of their eligible patient volume. EPs must utilize their provider data.

Eligible Professional Data Elements					Provider Enters	
	AIU Type	A	Adoption		Select 1	
		I	Implementation			
		U	Upgrade			
	Provider Type	Physician Dentist Nurse Practitioner Certified Nurse Midwife Physician Assistant (PA) in FQHC/RHC			Select 1	
		FQHCs RHCs PA Led Type	Primary Provider in Clinic		Select 1	
			Clinical/Medical Director at Clinical Site			
			Owner of an RHC			
FQHC RHC	**EP Practices Predominantly Reporting Period**	A 6 month period in the Prior Calendar Year			to	
FQHC RHC	**Practices Predominantly Percentage**	FQHC/RHC Facility Patient Encounters *in FQHC/RHC EP Practices Predominantly Reporting Period*				
FQHC RHC		Total Patient Encounters *in FQHC/RHC EP Practices Predominantly Reporting Period*				
PATIENT VOLUME	**Patient Volume Reporting Period**	A Continuous 90-day Period in the Prior Calendar Year			to	
PATIENT VOLUME	**Physician Type**	Physician Type	Pediatrician		Select 1	
PATIENT VOLUME			Non-Pediatrician			
PATIENT VOLUME	**Patient Encounters**	Total Medicaid Patient Encounters			Select One	
PATIENT VOLUME					Select One	
PATIENT VOLUME		Total Patient Encounters				
PATIENT VOLUME		Needy Individuals Patient Encounters	Medicaid Title XIX Patient Encounters			
PATIENT VOLUME			CHIP TITLE XXI Patient Encounters			
PATIENT VOLUME			Patients Paying Below Cost Patient Encounters			
PATIENT VOLUME	**Hospital-Based Patient Encounters**	Total Inpatient Hospital Patient Encounters				
PATIENT VOLUME		Total Emergency Department Patient Encounters				
PATIENT VOLUME	**Practice** *(Group Practice or Clinic)*	Name				
PATIENT VOLUME		Address				
PATIENT VOLUME		Patient Volume Methodology			Select 1	
PATIENT VOLUME		List Each EP in Practice with AHCCCS' Provider ID Number *(EP uploads documentation)*				

Acronyms

The following acronyms are used in this document:

Acronym	Definition
AHCCCS	Arizona Health Care Cost Containment System
AIU / AIU1	Adoption, Implementation or Upgrade; AIU for first year
ARRA	American Recovery and Reinvestment Act
ASU-BMI	Arizona State University's Department of Biomedical Informatics
AzHeC	Arizona Health-e Connection
CAH	Critical Access Hospital
CCN	CMS Certification Number (applies to hospitals only); previously know as the OSCAR Provider Number
CHIP	Children's Health Insurance Program (also known as KidsCare in Arizona)
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year (used by Eligible Professionals)
DHCM	AHCCCS' Division of Health Care Management
EH	Eligible Hospital
EHR	Electronic Health Record
EHR IP	Electronic Health Record Incentive Program
EFT	Electronic Funds Transfer
EP	Eligible Professional
ePIP	Electronic Provider Incentive Payment System
FFY	Federal Fiscal Year (used by Eligible Hospitals in the EHR Incentive Program)
FQHC	Federally Qualified Health Center
FY	Fiscal Year (used by Hospitals);
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HSAG	Health Services Advisory Group
I&A	CMS Identity & Access Management

Acronym	Definition
IHS	Indian Health Services
MCR	Medicare Cost Report
MU / MU1	Meaningful Use; Meaningful Use for first year.
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
ONC	Office of the National Coordinator for Health Information Technology
ONC-ATCB	Office of National Coordinator -Authorized Testing & Certification Board
PA	Physician Assistant
PECOS	Provider Enrollment Chain and Ownership System
PMMIS	Prepaid Medicaid Management Information System
REC	Regional Extension Center
RHC	Rural Health Clinic
TIN	Taxpayer Identification Number; (Also see Payee TIN)
UAR	Arizona Hospital Uniform Accounting Report

Glossary

The following terms are used in this document.

Term	Definition
Adoption, Implementation or Upgrade	For Medicaid's EHR Incentive Program, the Adoption, Implementation or Upgrade (AIU) criteria requires the provider to obtain certified EHR technology for the first year (AIU1) of participation. This means that they must: o Acquire, purchase, or secure access to certified EHR technology; o Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or o Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.
AHCCCS Provider	A person or company participating in the Arizona Health Care Cost Containment System that are qualified to render covered service and complies with AHCCCS policies and procedures for provider participation.
Attestation	Medicaid's EHR Incentive Program attestation process allows the providers to attest to the EHR Incentive Program's eligibility criteria as they demonstrate adoption, implementation, upgrade or meaningful use of EHR technology.
Average Length of Patient Stay	For purposes of determining Medicaid's EHR Incentive Program eligibility, an Eligible Hospital's Average Length of Patient Stay is calculated using fiscal year data from the most recent filed Medicare Cost Report (MCR). Observation stays are considered to be outpatient services and therefore cannot be included in the average length of stay calculation.
CMS Certification Number	CMS Certification Number (CCN) is a unique hospital identifier used to verify Medicare/Medicaid certification. For purposes of determining the EHR Incentive Program eligibility, a multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the EHR incentive payment.
EHR Reporting Period	For demonstrating meaningful use of Electronic Health Records (EHRs), Eligible Providers must use the EHR reporting period associated with that payment year. For the first payment year (MU1) that an Eligible Provider is demonstrating meaningful use, the EHR Reporting Period is a continuous 90-day period within the payment year; for subsequent years, the EHR Reporting Period is the full payment year. For EPs, the payment year is on a Calendar Year basis. For EHs, the payment year is on a Federal Fiscal Year basis. There isn't an EHR Reporting Period associated with Adoption, Implementation, or Upgrade of certified EHR technology.
Eligible Hospitals	For purposes of determining Medicaid's EHR Incentive Program eligibility, Eligible Hospitals are: o Acute Care Hospitals are health care facilities where the average length of patient stay is 25 days or fewer and with a CMS Certification Number (CCN) that has the last four digits in the series 0001–0879 or 1300– 1399. o Children's Hospitals are a separately certified children's hospital, either freestanding or hospital-within hospital that predominantly treats individuals under 21 years of age and with a CMS Certification Number (CCN) that has the last 4 digits in the series 3300–3399.
Eligible Professional	For purposes of determining Medicaid's EHR Incentive Program eligibility, Eligible Professionals are: o Physicians (primarily doctors of medicine and doctors of osteopathy) o Nurse practitioner o Certified nurse-midwife o Dentist o Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.
Eligible Providers	Eligible Professionals and Eligible Hospitals who have registered with the CMS Registration and Attestation System and request an EHR incentive payment.

Term	Definition
FQHC	Federally Qualified Health Center. An entity which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
Hospital-Based	For purposes of determining Medicaid's EHR Incentive Program eligibility, Hospital-based Eligible Professionals have 90 percent or more of their covered professional services in a hospital setting and therefore do not qualify for the Medicaid EHR Incentive Program. A hospital setting is an inpatient hospital place of service or an emergency department place of service. Hospital-Based Encounters are encounters received at an inpatient hospital place of service or at an emergency department place of service.
IHS	Indian Health Services. A division of the U. S. Public Health Services; administers the system of hospitals and health centers providing health services to Native Americans and Native Alaskans.
Meaningful Use	For Medicaid's EHR Incentive Program, the Meaningful Use criteria requires the provider to provide quantitative measures to substantiate meaningful use for a contiguous reporting period of 90 days for the first Meaningful User year (MU1) and the entire year for subsequent MU years. Medicaid Meaningful Use attestations will not be available in 2011. Functionality is currently being developed for deployment in 2012.
Medicaid Encounter	For purposes of calculating EP Patient Volume, Medicaid Encounters are services rendered to an individual on any one day where Medicaid paid for part or all of the service, individual's premiums, copayments and/or cost-sharing. For purposes of calculating FQHC/RHC EP Needy Individuals Patient Volume, Needy Individuals Patient Encounters are services rendered to an individual on any one day to where Medicaid or Children's Health Insurance Program (CHIP) paid for part or all of the service, individual's premiums, co-payments, and/or cost sharing; or Services rendered to an individual on any one day on a sliding scale or that were uncompensated. For purposes of calculating EH Patient Volume, Medicaid Encounters are: o Services rendered to an individual per inpatient hospital discharges where Medicaid paid for part or all of the service, individual's premiums, co-payments, and/or cost-sharing; o Services rendered to an individual in an emergency department on any one day where Medicaid paid for part or all of the service; premiums, co-payments, and/or cost-sharing.
Needy Individuals	FQHC or RHC patient receiving medical assistance from Medicaid (Title XIX) or the Children's Health Insurance Program (Title XXI), individual furnished uncompensated care by the provider, or individuals furnished service either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay. Note that anyone paying per the sliding scale with payments over the calculated cost of service does not qualify as a needy individual.
Patient Volume Reporting Period	A Continuous 90-day Period in the Prior Calendar Year
Patient Volume Threshold	Total Medicaid patient encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100 (FR page 44487).
Payee TIN	The Tax ID Number of a provider's payment designee. (Also see TIN)
Pediatrician	For purposes of the Medicaid EHR Incentive Program, Pediatricians are physicians who treat and diagnose illness and injuries in children under the AHCCCS Medicaid program. As such, Pediatricians must be an AHCCCS Provider who meets the physician scope of practice rules, hold a Doctor of Medicine or Doctor of Osteopathy degree, and hold a current license and board certified in Pediatrics.
Practices Predominantly	Eligible Professional for whom the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year occurs at a FQHC/RHC.
Registration	Medicaid's EHR Incentive Program registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a Federal and State level registration process.
RHC	Rural Health Clinic. A public or private hospital, clinic or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a Medically Underserved area or a Health Professions Shortage Area and use a physician assistant and/or nurse practitioners to deliver services. A rural health clinic must be licensed by the state and provide preventive services.
TITLE XIX	The section of the Social Security Act which describes the Medicaid program's coverage for eligible persons, (i.e., medically indigent/needy).
TITLE XXI	The section (or Title) of the Social Security Act that authorizes the State Children's Health Insurance Program known as KidsCare in Arizona.